

01 <input type="checkbox"/> Insured's GIC-ID (usually Soc. Sec. #)		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth / /		Dept. ID # or Agency/Division # /	
Name - Last				First		MI	
Address				<input type="checkbox"/> This is a new address		City	
Date Entered Service / /		Bargaining Unit/Union Name		HR/CMS or UMASS Employee ID #:		Home Phone ()	
						Work Phone ()	
02 <input type="checkbox"/> LIFE, HEALTH AND LTD COVERAGE							
New Enrollment: <input type="checkbox"/> Change: <input type="checkbox"/>				Effective Date: / 01 /			
<input type="checkbox"/> Basic Life Only <input type="checkbox"/> Long Term Disability (LTD) <input type="checkbox"/> Basic Life and Health (Select one of the Health Plans below)				Annual Salary: \$ _____		Cancel Coverage <input type="checkbox"/> Long Term Disability (LTD) <input type="checkbox"/> Health Insurance <input type="checkbox"/> Optional Life Insurance	
Salary Effective Date: ____ / ____ / ____							
Health Plan <input type="checkbox"/> Fallon Direct (HMO) <input type="checkbox"/> Fallon Select (HMO) <input type="checkbox"/> Harvard Pilgrim Independence (PPO) <input type="checkbox"/> Harvard Pilgrim Primary Choice (HMO) <input type="checkbox"/> Health New England (HMO) <input type="checkbox"/> NHP Care – Neighborhood Health Plan (HMO) <input type="checkbox"/> Tufts Health Plan Navigator (PPO) <input type="checkbox"/> Tufts Health Plan Spirit (HMO-type) <input type="checkbox"/> UniCare State Indemnity/Basic CIC: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UniCare/Community Choice (PPO-type) <input type="checkbox"/> UniCare/PLUS (PPO-type) <input type="checkbox"/> Individual <input type="checkbox"/> Family							
Optional Life Please Check One: <input type="checkbox"/> Automatic Increase Indicate Multiple Factor (1-8): _____ Multiple Factor 2-8 times is allowed only with Automatic increase. Changing from Non Automatic to Automatic requires a medical form. <input type="checkbox"/> Non Automatic Increase Amount \$: _____ No more than \$1000 less than annual salary rounded down to the nearest \$ 1,000							
<input type="checkbox"/> Automatic Increase – Family Status Change Indicate Multiple Factor (1 – 4) _____ <input type="checkbox"/> Non Automatic Increase – Family Status Change Amount \$: _____ No more than \$1000 less than annual salary rounded down to the nearest \$1,000 <i>Marriage, divorce, birth/adoption, death of spouse. The GIC must receive documentation of family status change within 31 days of the event.</i>							
Please Check One: <input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker Yes, I have been tobacco free for the past 12 months and choose the lower optional life insurance rates							
03 <input type="checkbox"/> Name Change				Previous Name		New Name	
LEAVE OF ABSENCE						FOR GIC USE ONLY:	
04 <input type="checkbox"/> Leave Is: <input type="checkbox"/> With Pay <input type="checkbox"/> Without Pay						Effective Date: / 01 /	
Leave Type (You MUST Check one of the following):						Leave Pay Status: <input type="checkbox"/> Part <input type="checkbox"/> Full	
<input type="checkbox"/> Educational		<input type="checkbox"/> Maternity		<input type="checkbox"/> Military Caregiver (26 weeks)		<input type="checkbox"/> FMLA (12 weeks)	
<input type="checkbox"/> Personal Illness		<input type="checkbox"/> Sabbatical		<input type="checkbox"/> FMLA Military Exigency (12 weeks)		<input type="checkbox"/> Family (for dep < age 3)	
<input type="checkbox"/> Industrial accident		<input type="checkbox"/> Suspension		<input type="checkbox"/> Military		<input type="checkbox"/> Other	
* Industrial Accident (without pay), Maternity (without pay), and Personal Illness (without pay) leaves all require the employee to submit a Form 11 to the Group Insurance Commission with a letter from the agency head approving the leave of absence.							
Duration of Leave:		Start Date / /		End Date / /		Last Day on Payroll / /	
05 <input type="checkbox"/> Return to Payroll Deduction:				First Day Back on Payroll / /		FOR GIC USE ONLY: Effective Date: / 01 /	
INSURED CHANGES							
06 <input type="checkbox"/> Retirement		Date Retired / /		<input type="checkbox"/> ORP (Higher Ed Only) Fund Name:			
07 <input type="checkbox"/> Transfer to another Agency		Name of Agency Transferred to				Effective Date / /	
08 <input type="checkbox"/> Transfer from another Agency		Previous Agency				Effective Date / /	
09 <input type="checkbox"/> Termination Coverage (if elected)		Termination Reason					
		Termination Date ____ / ____ / ____					
		<input type="checkbox"/> 39 -Week Layoff Coverage <input type="checkbox"/> Deferred Retiree <input type="checkbox"/> COBRA (must complete COBRA application) <input type="checkbox"/> Conversion (contact carrier for application)					
Deduction Authorization: I authorize my employer, or direct my pension authority , to deduct from my payroll or pension check the amount required for the coverage I have selected. Long Term Disability Insurance (LTD): I understand that by not applying to be insured for Long Term Disability (LTD) insurance when first eligible, I may not apply for LTD Insurance until I have provided satisfactory medical evidence of insurability. Health Insurance: I understand that once I choose a health plan, I cannot change plans until the next annual enrollment, even if my doctor or hospital leaves the plan. Optional Life Insurance: I understand that by not applying to be insured for Optional Life Insurance when first eligible, I may not apply for or increase my Optional Life Insurance until I have provided satisfactory medical evidence of insurability or I have a qualified family status change. At Retirement: I hereby certify that I have filed an application for retirement and desire to continue my present coverage as a retiree. I also understand that if I am Medicare eligible, I am required to join one of the Group Insurance Commission's Medicare supplemental health plans to continue health coverage. Survivors: I am a surviving spouse and certify that I have not remarried and understand that if I do remarry I am no longer eligible for GIC coverage. Termination: I understand that by electing to continue coverage under COBRA or Conversion, I must complete and return the corresponding application in order for this coverage to go into effect.							
• If you are applying for Health Insurance, be sure to file a Form IDF to list family members.							
x _____		Date		x _____		Date	
Signature of Applicant				Signature of Authorized Official			
FOR GIC USE ONLY:		Entered		Verified		Political Subdivision	